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AUTHOR Gram, Anita M.
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ABSTRACT

This paper reviews the literature dealing with therapist neutrality or value-free treatment processes, and proposes that therapist values do play a major role in therapy. Supposed therapist neutrality in psychoanalyses, behavior therapy, and client-centered therapy is explored. The role of therapist values in client selection is discussed, and the client qualities reportedly preferred by therapists (i.e, young, attractive, verbal, successful, intelligent) are outlined. The influence of therapist values in client goal-setting and values changes is discussed. Studies reflecting the clash of counselor-client values are highlighted; and implications for therapy are proposed, including the need for counselor awareness and open discussion of values, and therapy for counselors. (Author/JAC)

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VALUE-FREE THERAPY?: AN EMPIRICAL REVIEW

Anita M. Gram

The University of Texas at Austin

Empirical evidence suggests that therapists' values are an integral part of therapy regardless of whether they are made explicit by therapists. Origins of the notion of value-free therapy are briefly explored. The role of therapists' values in client selection and therapeutic goal-setting is discussed; research on the influence of therapists' values on client values is highlighted. Implications for therapy and for research are proposed.

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In recent years the image of the psychotherapist as an impartial scientist involved in a value-free treatment process has come to be questioned on both theoretical and empirical grounds. There are various reasons why this image developed historically and why it continues as an integral part of some therapies today. However, more and more professionals are realizing that when psychology enters the realm of applied psychotherapy, value judgements are inevitably called for. Walters has expressed this view well.

> The therapist usually conceives of himself and is often represented as the detached, dispassionate scientist. A more realistic view would see him as an involved participant with an interest in the outcome, following a secterian psychotherapeutic doctrine or a combination of doctrines, the selection and practice of which are tinctured by his own basic philosophy of life (1958, p. 249).

This paper will explore briefly some of the reasons for supposed therapist neutrality in psychoanalysis, behavior therapy, and client-centered therapy. However, it is the major premise of this paper that therapists' values do play a major role in therapy. Their possible effects on client selection, therapeutic goals, methods and outcome will be outlined. Theoretical arguments as well as empirical evidence for the influence of

therapist values will be cited. Finally, implications for therapists will be suggested.

The Uses of Therapist "Neutrality"

Growing out of the scientific causality frame of reference, Freudian psychoanalysis was based on a disease model of neurosis and psychosis. One of the practical results of the medical model was to make the therapist an objective treater of mental disease. Another reason for therapist neutrality was built into Freud's theory of transference. In order to promote the transfer of unresolved conflicts to the analyst, it was essential that the analyst's true personality remain hidden. The patient would then imbue the therapist with qualities of another person and be able to work through conflicts. To this end, the analyst sits out of the patient's view during sessions, so that no reactions, including facial expressions are seen by the patient.

However, the notion of therapist non-involvement has fallen into disfavor with some Neo-Freudians and even traditionally trained analysts. Halmos (1965) cites many examples from The International Journal of Psychoanalysis putting emphasis on the personal values of the psychotherapist and the increasing importance of therapist direction and participation in sessions. He also cites such notable psychiatrists as Menninger, Szasz, and Fairbairn who have questioned the "scientific" neutrality of the therapist.

One of the more vocal opponents of the concept of therapist

neutrality is Seymour Halleck. He contends that, "Value systems, usually implicit, have always dominated the different schools of psychiatry" (1971, p. 32).

> Every psychiatrist who ever treated a patient has had some notion of what kind of life would be best for that patient. And every patient who has benefited from psychiatry has incorporated some of his doctor's values. Furthermore, by the very nature of his practice, the psychiatrist consistently takes positions on issues that involve the distribution of power within social systems--issues that have political implications (p. 32).

The "mental illness" model, of which psychiatry was and is a major promoter, is another contributor to the concept of supposed therapist neutrality. As long as the "doctor" is treating the "symptom" there is no need for value judgements. However, writers such as Szasz (1960), Halleck (1971), and Tennov (1975) have repeatedly challenged this conception. Szasz contends that psychiatry is dealing with "problems in living" rather than mental illness and that value judgements are involved despite claims to the contrary.

Behavior therapists have traditionally sought to extricate their therapeutic processes from sticky value questions with an argument similar to that of the medical model: since they concentrate on changing behavior, i.e., symptom removal, value judgements are not involved. This is further reinforced by the guiding principles of scientific method. However, by eschewing

value questions behavior therapists are merely reinforcing the normative, adjustment model of mental health.

There has been a growing realization that even behavior therapy does not operate in a value-free vacuum. A recent issue of Journal of Consulting and Clinical Psychology (1980) contains several articles grappling with the issue of ethics in behavior therapy. As Bergin (1980) notes, "It will not do for therapists to hide their prejudices behind a screen of scientific jargon" (p. 11). He further says of behavior therapy, "It is now clear that its methods are directed toward goals that are subjectively chosen and even matters of controversey" (p.12). Examples of this are such subjective goals as changing the sexual orientation of homosexuals and uses of behavioral control programs in prisons. Kitchener (1980) has made an attempt to confront ethical issues, but behaviorism which claims to deal with scientific observable "facts" has not yet dealt adequately with the problem of values.

Another type of psychotherapy which claims therapist neutrality is client-centered therapy. By furnishing the necessary conditions of empathetic understanding and unconditional, positive regard the therapist allows clients to come to their own understanding of their problems. Solutions are not suggested, nor does the therapist foist his/her views onto the client. Instead a sort of "natural" growth process is said to occur in the client.

In an important study Truax (1966) provided evidence that rather than non-directiveness, differential reinforcement was taking place in Rogerian psychotherapy. Recordings of Rogers'

therapy sessions with a client were analyzed for differential responses to 9 patient behavior classes. Five of the 9 classes elicited differential therapist responses with regard to empathy and acceptance. Furthermore, 4 out of the 5 behavior classes showed increased frequency over time, demonstrating possible reinforcement effects. This is evidence for therapist non-neutrality in client-centered therapy.

Other theorists have postulated possible therapist influence in broader terms. Watzlawick, Beavin, and Jackson (1967) have asserted that, "One cannot not communicate" (p. 49), and that any type of response, even silence has communication value. There has been much research on the different aspects of nonverbal communication, and its potency has been empirically shown (Harper, Weins, & Matarazzo, 1978). White sums up the influence of the therapist.

> How naive we have been to suppose that our preferences could be withheld from communication. . . . The counselor may censor his personal preferences at the level of verbal statement, but he is easily betrayed in his body language, his tone of voice and the items to which he chooses to respond. (pp. 3-4)

Therapist Values in Client Selection

Therapists initially reveal the personal preferences in their choice of whom to treat. While to some extent this is influenced by the particular system of psychotherapy espoused by the therapist, there is still room for considerable therapist

choice. What are the general client qualities preferred by therapists? Schofield (1963) has summarized them with the acronym YAVIS. That is, they are young, attractive, verbal, intelligent, and successful.

The preference for youthful, intelligent clients is echoed by Lowe (1969), in addition to "a working conscience, a tendency to introspection, and motivation for self-improvement" (p. 39). This is understandable in light of a therapist's obvious wish for candidates who will successfully complete therapy. However, it tends to deny treatment to those who may be most in need of it, i.e., the unsuccessful, non-verbal, and unintelligent. Furthermore, a tendency has been noted by Hollingshead and Redlich (1958) for therapists to prefer patients of their own socioeconomic status. While potential clients from lower classes may lack counseling services for lack of financial resources, the role of therapist preference must not be overlooked.

It is my opinion that this psychological elitism has contributed to the traditional lack of concern with therapist values. As long as clients and therapists shared the same implicit value structure and such underlying assumptions as the value of the work ethic, these could be ignored more easily. However, with the spread of community mental health centers and the increasing interest by the middle class in psychological issues, therapist--client value clashes can no longer be ignored.

Therapist Values in Goal Selection

The goals that a therapist chooses for his/her clients are determined by both the nature of the problem and by the way that the therapist conceives of the problem. As Strupp (1978) explains, the therapist "cannot escape the necessity of (1) forming some notions or hypotheses about the patient's 'problem' or difficulty, and (2) deciding what needs to be done to bring about an improvement" (p. 6). He believes that we must ultimately confront questions of values in making these decisions.

Some of these values are built into the system of psychotherapy that the clinician espouses. For instance, some therapists value self-knowledge while others such as Fritz Perls put more emphasis on self-expression; some emphasize adjustment whereas others such as Maslow value moving beyond adjustment to creativity.

When the goal of therapy is adjustment of the client to his/her life situation some questions about values are raised. This goal may be inadvisable in light of the fact that some "mental illness" may be a way of coping with an intollerable situation. One phenomenon which brought this problem to light and perhaps exacerbated it was the phenomenon of changing roles for women and men. The adjustment notion of mental health came under particular attack by feminists who argued that in some situations it was a sign of health for the woman <u>not</u> to acquiesce and "adjust" but to protest and/or get out of an unhealthy situation. In other words, the environment and social expectations were seen

as being "unhealthy" and the helping professions were accused of ignoring the real problem by labeling the person as "ill," à la Szasz.

The male-dominated psychiatric profession particularly came under fire for supposedly promoting the status quo for their patients who were predominantly female (Chessler, 1972). And, indeed, a report from the American Psychological Association(1975) shows that such claims are not limited to the assertions of a few radicals, but that sexist practices are evident even to other professionals. Since these accusations have rocked the psychotherapy profession, the question of values and goals can no longer be be dismissed or answered in terms of scientific treatment.

The Influence of Therapist's Values on Client Values

What effect do the values of the therapist have on the values of his/her clients? There is growing evidence that clients' values change during successful therapy and not just in the direction of a more adaptive set of beliefs, but by becoming closer to their therapists' specific beliefs. Furthermore, these changes in clients' value systems have, in several studies which will be discussed below, been associated with positive therapy outcomes on several measures.

Frank (1974) stressed the persuasive element in psychotherapy, and Beutler (1979) finds it "paradoxical" that therapy should be advocated as a means of change "while disavowing its persuasive element" (p. 432). He asserts that, "By its very nature psychotherapy is designed to persuade individuals to change significant

attitudes about themselves or about the world" (p. 432). However, when the values changed in therapy are shown not only to be changed to a more mature set of values, but those specifically held by one's therapist, questions of ethics inevitably follow.

One of the earliest studies on changes in clients' values following psychotherapy was done by Rosenthal in 1955. Although they evaluated only 12 neurotic clients, their findings prompted further research in this area. The clients were tested before and after therapy using a 60-item questionnaire centering on three areas of common conflict: sex, aggression, and authority. They found that patients who improved tended to change their values to become more like their therapists, while those who didn't improve in therapy were less like their therapists. Rosenthal inferred that,

> It may be that the therapist communicates his values to the patient in many unintended, subtle ways, even when trying to avoid so doing. The patient, who is often sensitized to the therapist's every word and inflection, may be able to receive these communications, and because of his trust, admiration, and respect for the therapist, may permit himself to be influenced by them. (p. 436)

This is particularly plausable in light of Fiedler and Senior's (1952) finding that clients tend to idealize their therapists.

Later studies using a greater number of subjects tended to give support to Rosenthal's finding. Landfield and Nawas (1964) investigated improvement in therapy as correlated with value change for 36 college student clients. They found that improved clients tended to change towards their therapists' values.

Beutler, Pollack, and Jobe (1978) found similar results when correlating improvement in therapy and acquisition of therapist values. These studies and others cited by Beutler (1979) in a literature review lead to the conclusion that the values of clients do change during the course of successful therapy.

The question may be raised--are clients adopting values that are more mature and adaptive rather than those of their specific therapist? A study designed to measure this was designed by Welkowitz, Cohen, and Ortmeyer (1967). They studied 38 therapists and 44 of their clients who had been seen in therapy for one to nine months. The Way to Live scale and the Strong Vocational Interest Blank were used to assess therapist and client values. They found that therapists and their own clients had significantly more similar values when compared with randomly mixed client--therapist pairs. (Since therapists did not share a homogeneous value system these comparisons were meaningful.) Therapists were also asked to rate each of their clients on a 6-point scale from (1) Much worse to (6) Marked improvement. It was found that clients who were rated as most improved had more similar values to their therapists than those who were rated as least improved.

A matter of concern is that some client values which appear to change in therapy are values not necessarily related to a therapy situation. Beutler et al. (1978) asked clients and therapists to complete a series of value questionnaires covering such diverse topics as: others approval, God, social laws, Communism, sexual behavior, and Christistianity. After 12 sessions clients again

completed the questionnaires, along with a questionnaire on satisfaction with therapy and overall improvement ratings for themselves. They found that global improvement ratings correlated significantly (r=.76) with changes in values towards their therapists' values on seven scales. Beutler and his colleagues speculate, "Apparently, adoption of a therapist's view of life facilitates a patient's sense of positive growth" (p. 198).

What are the possible reasons for changes in clients' value systems leading them to values similar to those of their therapist? One theory was proposed by Welkowitz et al. (1967) to account for the changes. Equilibrium theory states simply that in a social interaction dyad there is movement toward equilibrium, with the inference that "interaction between two people of some duration leads to a growing similarity of their values" (p. 48). Equilibrium theory gains strength from such areas as dissonance theory, psycholinguistics, and values theory, and may form part of an explanation for value change in therapy (Welkowitz et al., 1967).

Persuasion Theory applied to the therapy dyad is an explanation posed by Beutler (1979). He suggests that psychotherapy provides a likely situation for two of the significant persuader variables, credibility and expectancy effects. Credibility focuses on the perceived degree of "expertness" of the therapist, with greater status leading to greater persuasion. This has been applied in clinical studies in which perceived status of therapists was significantly positively correlated with improvement in therapy (Truax, Fine, Moravec, & Millis, 1968).

Expectancy effects in therapy can involve both clients and therapists. Therapists usually select as clients those whom they expect to be able to treat effectively, which in turn provides for further client investment in the therapy process. Clients' initial expectations for improvement in therapy are usually so strong that Shapiro (1971) has suggested that much of the real improvement that occurs in therapy may be due to this factor. Franks (1974) makes this point even more strongly when he compares psychotherapy to some aspects of religious and magical healing.

Counselor--Client Value Clashes

It can be seen from the above studies that therapist values do play a part in the therapy situation, affecting not only treatment goals and procedures, but also in subtly affecting clients' values. How might this be a specific problem for therapists and clients? The issue of changing roles for women was mentioned earlier as a source of potential conflict. Feminist therapy grew out of the realization that many traditional psychotherapies denied growth to women, both in theory and practice. For example, a therapist who believes that motherhood is the ultimate fulfillment for a woman is unlikely to be very encouraging to a young woman wavering on the brink of a big career decision.

Another example of an area for a potential values clash is religion. While most therapists carefully avoid references to their personal religious preferences (or lack thereof), there are

some value clashes with religion built into the commonly held groundings for therapy. These are based on clinical pragmatism and humanistic idealism, and are so widespread that they are rarely examined. Bergin (1980) has shown how these assumptions come into direct conflict with traditional theistic or religious values. Three of his list of eight contrasts are shown here as an example of how supposedly neutral values of therapy are not neutral with respect to theistic values.

Theistic	Clinical-Humanistic
God is supreme. Humility, acceptance of (divine)authority, and obedience are virtues.	Humans are supreme. The self is aggrandized. Autonomy and rejection of external authority are virtues.
Self-control in terms of absolute values. Strict morality. Universal ethics.	Self-expression in terms of relative values. Flexible morality. Situation ethics.
Love, affection, and self-transcendence are primary. Service and self-sacrifice are central to personal growth.	Personal needs and self-actualization are primary. Self-satisfaction is central to personal growth.

(Bergin, 1980, p. 100).

It should be obvious from these contrasting examples that commonly held assumptions by clients and therapists can lead to clashes in values. If psychotherapists are the "secular priests" of the modern era, many clients may be getting more than they bargained for.

Conclusions and Implications

Research has shown that therapist values do indeed play a role in therapy. Despite efforts at therapist neutrality, therapists cannot avoid the role of expert or at least helper. For no matter how much the therapist strives for an egalitarian partnership it is still the client who has the problems and the client who is paying for help from a professional. In an effort to be helped the client may unwittingly assume his therapist's values, even in irrelevant areas as some studies have shown.

What are therapists to do about values in light of these findings? Several suggestions can be made.

1. Clinicians should be aware of the subtle ways that they may be conveying their own values to clients. While taking their own sensitivity to client cues for granted therapists may forget that some clients are equally sensitive to cues from their therapist. Krasner (1967) has made this point particularly clear. "For the therapist not to accept this situation and to be continually unaware of influencing effects of his behavior on his patients would in itself be 'unethical'" (p. 204).

2. Therapists are often not aware of the interaction between their values and the therapeutic process. This is particularly true for those therapies which are in the scientific tradition. It is important that therapists admit that their own biases and values affect their choice of clients as well as their treatment goals. Alternate goals, perhaps more in keeping with the client's value system should be given consideration.

3. One way for therapists to become more aware of their own values is through personal therapy for themselves. Besides the other benefits that may accrue from this, it may help therapists examine their own implicit values, and be less likely to unwittingly transmit them to their clients. Special Values Clarification Workshops geared to helping professionals would be another possibility.

4. Some have advocated that clinicians openly speak of their own values with clients so that clients will be able to more easily deal with them as an overtissue. Barrett and her colleagues advocate this approach: "Each therapist should directly communicate his or her values to the client" (1974, p. 14). This may be helpful in some cases. For example, in religious-oriented counseling services or in feminist therapy certain assumptions that are an integral part of therapy should be made clear to the client at the begining of therapy. However, in other therapy situations it would be hard for the therapist to do this without sounding like an advocate for his/her own values or opinions.

5. Therapists must develop more explicit concepts of mental health. In the past these standards have been implicit and rarely examined. When operating without explicit goals, Mahrer points out that, "We are terribly limited in what we seek to accomplish--without ever knowing that we are limited, and without knowing other possible horizons of what might be accomplished" (1978, p. 5). Maslow has been one of the major proponents

of the study of healthy personality traits. Coping Theory has been advanced as another way of studying the development of healthy behaviors. Whether a therapist chooses one of these formal frameworks or uses one idiosyncratic to his/her own values it is important that ideas about what constitutes mental health become an explicit, active part of therapy practice.

There are signs that more and more clinicians are coming to realize the importance of values in the therapy situation. Woolfolk and Richardson (1980) have concluded that

> In the dialogue between therapist and client we should begin to move beyond the pragmatic ethos of self-interest and toward a consideration of those aspects of existence which might be affirmed as intrinsically meaningful and important. . . . Our profession can cultivate, rather than discourage, that proclivity to strive for higher things that was once at the core of our civilization. (p. 9)

But perhaps the most outspoken advocate of the role of values in therapy has been Abraham Maslow. He contends that, "We may soon even define therapy as a search for values, because ultimately the search for identity, is, in essence, the search for one's own intrinsic, authentic values" (1968, p. 177). In the movement of "growth" therapies there may well be such a central place for values change. But whether or not one agrees with such suggestions as Maslow's, there is no denying the research evidence of the influence of the therapist's values in therapy. Ethics

demand that we not only consider values theoretically, but take cognizance of them in our clinical practice.

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